Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 13, 2009

Meeting Date, Time, and Location

Date: Friday, February 13, 2009
Time: 11:00 a.m. – 2:00 p.m.
Place: Two Boylston Street, Boston

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Deborah Chollet, Ph.D., Mathematica Policy Research, Inc. ✓ Chris Koller, RI Health Insurance Commissioner ✓ Suzanne Felt-Lisk, Ph.D., Mathematica Policy Research, Inc.	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC

Meeting Minutes

Co-Chair Leslie Kirwan introduced Representative Harriett Stanley, Chair of the Joint Health Care Financing Committee, as the new member of the Commission. She identified the three payment models that are the topics of today's meeting: Patient-Centered Medical Home (MH), Pay-for-Performance (P4P), and global capitation.

Co-Chair Sarah Iselin reminded the attendees that Commission materials are available on the Commission's website. The next Commission meeting will be February 24 from 2pm to 5pm. Two speakers and topics have been confirmed. Glen Hackbarth and Harold Miller will be presenting on episode-based models. There will also be a presentation on evidence-based coverage. Materials will be sent to the Commission members in advance.

I. <u>Report on stakeholder meetings</u> – Michael Bailit, Bailit Health Purchasing

Michael Bailit, who was joined by Commissioner Iselin and by members of Secretary Kirwan's staff, reported meeting with the following stakeholder groups:

- Physicians: specialty societies, large independent physician groups, and groups affiliated with hospitals;
- Hospitals: community hospitals, teaching hospitals and large safety net hospitals;
- Consumer advocates;
- Organized labor groups;

- Health plans, and
- Community health centers.

In addition he has met with the Commonwealth Health Insurance Connector and briefed the Cost Containment Committee of the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board. He will be meeting with employer representatives and EOHHS representatives in the future.

The purpose of these meetings was to provide background about the role of the Commission and to review the payment reform principles being developed by the Commission.

Mr. Bailit identified several key points of understanding that the attendees took from the meeting:

- Terminology can be an impediment to communications. For example, the term "provider" means different things to different stakeholders.
- All stakeholders understand the difficulty of this endeavor. They also acknowledge that payment reform alone is not enough to address all issues driving up health care costs and that there is no guarantee of success.
- Several stakeholders thought that a vision statement regarding desired outcomes should be added to the principles.
- Many stakeholders believe integration of the delivery system will provide better value; there is disagreement as to whether real or virtual integration will be necessary to achieve the goals of the payment reform.
- All affirmed the importance of broad stakeholder participation in this process.

II. Review of proposed revised payment reform principles – Michael Bailit, Bailit Health Purchasing

Mr. Bailit identified new concepts to add to the statement of principles as a result of the stakeholder meetings. Suggested additional are the following:

- No one payment model will work for all providers or in all regions of the Commonwealth due to the heterogeneity of the delivery system.
- Payment reform must address the problem of a shortage of primary care physicians.
- Payment report should seek to balance payments for cognitive, preventive, chronic and interventional care, and be sensitive to the current cross-subsidization occurring within provider organizations as a result of the lack of balance.
- Implementation should be phased in with time and resources dedicated to evaluation, identification of unanticipated consequences, and mid-course corrections.
- Payment methodologies should be transparent to all, including patients and providers.
- Payment reform must be designed with an awareness of the interactive effects of payment model with delivery system organization and with health benefit design.
- Risk adjustment must contemplate not only differences in health status, but in socio-economic status, since lower income groups tend to have lower levels of adherence to clinical instruction.

A second round of stakeholder meetings will be held following the Commission's fifth meeting.

Commissioners' Questions

Question	Speaker's Response
Were there any objections expressed to moving away from a fee-for-service payment methodology?	Most agreed there was a need to move away from FFS. Some wanted to keep a modified FFS methodology on the table.
Was there any sense of urgency among the stakeholders	No. The sense of urgency was conveyed by the State to the stakeholders. In general, stake-holders perceived great opportunity coupled with a sense of trepidation regarding potential risks.

It was noted that even if the Commission wanted to move away from FFS, there may continue to be a place for FFS as a way to encourage more of something that the system wants to promote.

III. Overview of payment models – Deborah Chollet, Mathematica Policy Research

Dr. Chollet provided the following overview of payment models. Payment models aggregate payments at different levels. FFS pays at the service level. Episode-of-care models bundle groups of services (including physician and facility services) as a basis of payment. Global payment models bundle payments at the patient level. As bundling increases, there is more financial risk to the providers receiving the payment. Quality incentives tend to be in the form of bonuses for meeting quality/value targets.

Dr. Chollet summarized the characteristics of five payment models as follows:

Fee-for-service

- Providers are paid for individual services performed.
- Payments may be charge based, cost based, or prospective
- If payments are prospective there is no incentive to increase unit costs, but there are incentives to increase the volume of services and provide more costly mix of services.

Pay-for-Performance

- P4P is usually built on a FFS base. P4P increases payments for improved processes of care that are evidence based and for occasionally for improved quality outcomes.
- The goal of P4P is to improve quality and effectiveness. It has not been proven to save costs.
- Payments are usually low and there are lots of different measures used by different payers, so the effect of P4P is muffled and it is hard to know what is achieved.
- P4P does not necessarily counter the incentives of the underlying payment system. Payments would have to be large to do so.

Episode of care payments

- Payment model provides prospective payments for a clinical episode of care. Payments may be risk adjusted.

- It is in the early stages of development, and is usually developed around specific diagnoses.
- There is some provider risk, but it is limited to the cost of care, not the occurrence of the episode.
- There are incentives to constrain unit costs, volume and service mix.

Global Payments

- Global payments are fixed payments per patient per month for some or all of the services provided. The difference between partial and full global payments is the range of services for which the provider is responsible.
- There is high provider risk for both cost of services and occurrence of need for services.
- There is a strong incentive to constrain unit cost, volume and service mix.
- Global payments may be adjusted for severity or performance.

Medical Home

- This model focuses on primary care, disease management and care coordination.
- There is a basic and an advanced model. The basic model focuses on care coordination with the patient. The advanced model includes DMR, e-prescribing, performance reporting and care coordination.
- The Medical Home can be built on any payment model.
- The Medical Home is a way of approaching the patient, rather than a different payment system.
- There is no evidence of reduced costs.

Dr. Chollet offered the following check list of major payment systems issues to consider when evaluating different payment models:

- How does the payment system perform regarding incentives for patient selection and access to care?
- Does the system have anything to encourage improvement in quality, and short-term costs.
- Does the system have an impact on the longer term cost trend, which includes unit cost, volume and service mix?
- Are the risk-bearing entities stable? How are downstream risks reported and regulated by the state insurance department.

IV. Presentation regarding medical home – Michael Bailit, Bailit Health Purchasing

Mr. Bailit provided background on the development of the Patient Centered Medical Home (MH). The business case for the MH is based on research that demonstrates that health systems that are primary care focused generate lower cost, higher quality and fewer disparities than do systems that are specialty focused. The US has a specialty care focused health care system. Other research has evaluated the Chronic Care Model, which is the chassis for much of the NCQA standards, and the research found improved quality. Fewer evaluations have been done on cost and utilization, but most have been positive. The shortage of PCPs will continue without change.

MHs have eight distinguishing characteristics:

- Personal physician/clinician;
- Team-based care;
- Proactive planned visits instead of reactive, episodic care;
- Tracking patients and their needed care using special software (patient registries);
- Support of self-management of chronic conditions;
- Patient involvement in decision making;
- Coordinated care across all settings, and
- Enhanced access.

Currently, there are many pilots and demonstration projects across the US. There are two reasons why the MH pilots involve payment reform: practices are asked to perform more services that traditionally are non-billable services; and there is a need for incentives to move from volume based to quality based practices.

There are eight payment models across the US; most are built on a FFS model:

- FFS with discrete new codes for traditionally un-reimbursable services;
- FFS with higher payment levels for standard billing codes;
- FFS with lump sum payments to cover additional costs of redesigning the practice;
- FFS with a separate PMPM fee;
- FFS with a separate PMPM fee and with P4P bonuses;
- FFS with a PMPY payment;
- FFS with lump sum payments; P4P and shared savings, and
- Comprehensive payment with P4P (risk-adjusted PMPM comprehensive payment covering all primary care services)

Payment amounts typically range between $2.50 pmpm and $5.50 pmpm. The CMS demonstration project will pay considerably higher: tier 1= $27.12/$80.25 and Tier 2 = $35.48/$100.35.

Mr. Bailit identified two possible paths for Massachusetts:

1. Sponsor a multi-payer demonstration across the Commonwealth with participation of all major insurers and MassHealth, and of a diverse range of primary care practices. This model is attractive, but its value has not yet been sufficiently demonstrated as a means to reduce costs.
2. Implement the medical home statewide with all primary care practices in a phase-in process. It is clear that the system needs to be rebalanced to better emphasize, support and reward primary care, and the existing evidence is adequate to support the investment.

Commissioners' Questions:

Question	**Speaker's Response**
Does this system have any accountability for controlling costs outside of the medical home?	There is some indication that the MH system can control costs, but there are no explicit incentives to do so.
How are these systems financed?	Most are demonstration projects that have built in evaluation. Most of the dollars are invest-

Question	Speaker's Response
	ment dollars whereby payers are investing in a promising model upfront and then evaluating the results.
Are ER costs included in model 8?	No, but bonus payments look at efficiencies, including the use of ER.
Can this model be applied to smaller practices? Is there a critical mass that is needed?	It is harder for smaller practices. Some demonstration projects have tried to address this issue by creating shared resources for care management services.
Can this model be applied to employed practices?	Yes.
Do participants already have infrastructure in place?	No. PCPs uniformly want to participate in demonstration projects. There is no hesitation because of the short term nature of a demonstration project. Enhanced fees are a draw. Others are drawn to the model.

V. Medical home case study presentation – Chris Koller, Rhode Island Health Insurance Commissioner

Mr. Koller presented an overview of the medical home initiative in Rhode Island being facilitated by his office.

- CSI Rhode Island is a statewide, multi-stakeholder collaborative designed to align quality improvement goals and financial incentives among RI's health plans, purchasers and providers, in order to develop and support a sustainable model for the delivery of chronic illness care in primary care settings. It provides enhanced payments to PCPs for the delivery of high quality chronic illness care and establishment of a "Medical Home" based on NCQA standards. It is a two-year pilot that began on October 1, 2008. Harvard School of Public Health will be evaluating the pilot.
- Underlying principles recognize that improving chronic illness care requires re-design of the delivery system. For successful delivery system change there must be external standards and training; incentives and disincentives aimed at the provider site must be aligned across payers, and there must be measurements. RI believes that it must be piloted first.
- RI believes that it must be an all-payer initiative in order to make the numbers work for the practices so that there are enough dollars and patients and required standards to bring about change.
- Participants include:
    - Payers – all except Medicare.
    - Purchasers – the two largest private sector employers, RI Medicaid, State employees, and RI business Group on Health.
    - Providers – the largest PCP organizations (including community health centers and hospital based clinics), RI Medical Society, RI AAFP and RI ACP.
    - State – Office of the Health Insurance commissioner, Department of Human Services and Department of Health.

- The Commitments from each participant are as follows:
    - Providers – implement components of the NCQA PPC standards; participate in the local chronic care collaborative; submit self measurement and public reporting, and provide patient engagement and education.
    - Plans – pay a supplemental $3pmpm; pay the costs of the nurse care managers who are allocated across the sites, and provide shared data and common measures for UR measurement and feedback.
    - Self-insured employers – pay for programs for their workers.

- Elements of the CSI RI Pilot are as follows:
    - Common practice sites: all payers will select the same core group of practice sites in which to administer their pilot. This requires a common set of practice qualifications. CSI involves 25,000 covered lives; 28 physician FTEs, and a range of practice types.
    - Common services: all payers will agree to ask the pilot sites to implement the same set of new clinical services, drawn from the PCMH Principles. Sites must achieve NCQA PPC level 1 in 9 months and Level 2 in 18 months. The nurse case manager is hired by the practice, who works with all patients. The cost is paid by payers.
    - Common Conditions: pilot sites will not be asked by payers to focus improvement efforts on different chronic conditions. CSI RI addresses coronary artery disease, diabetes and depression.
    - Common Measures: all payers will agree to assess practices using the same measures, drawn from national measurement sets. Measures include structural measures (NCQA PPC-PCMH); outcome measures for three chronic conditions (from practice self-reporting) , and cost and utilization measures (ER, pharmacy, IP admission from claims)
    - Consistent Payment: the method and intent of incentive payments will be consistent across all payers. Payment is $3.00pmpm, plus cash to support the care managers. Plans and providers agreed to a common member attribution methodology.

- Mr. Koller identified the following barriers to convening a broad stakeholder coalition to pilot new payment models:
    - Large national payers have little incentive to participate in regional or state-level programs;
    - Payers fear losing competitive advantage and are not accustomed to collaborating with other plans;
    - Anti-trust concerns;
    - Medicaid and commercial plans are often not aligned;
    - Need Medicare to participate to cover all patients;
    - The PPO and FFS mindsets are diametrically opposed to this approach;
    - Hard to decide what success looks like;
    - The need for a positive ROI must be balanced with “Just Do It”;
    - Planning and implementation requires staff time, getting private practices to do non-reimbursed work and death by a thousand unforeseen cuts, and
    - Trust.

- Mr. Koller also identified the following opportunities to convening broad stakeholder coalitions:
    - The government serving as convener provides both a stick and the anti-trust soother;
    - Engaging major purchasers as advocates;
    - Engaging consumers to be advocates;
    - Developing physician leadership and collaboration;
    - Educating stakeholders regarding the need for delivery system-level reform;
    - Increasing awareness of conflict between medical home model and the dominant PPO benefit plan models;
    - Participating in national PCMH efforts, and
    - Greater alignment in PCP contracting beyond this project.

VI. Discussion of the medical home

Commissioner Questions and Comments:

Question and Comments	Speaker's Response
Do you see mandating this model statewide in the future?	We won't wait until the pilot is done to move forward. I am already talking with insurers about Phase II to roll out the model more widely.
Do you envision national plans pulling out because of this initiative?	No
Have the practices expanded access?	We are using NCQA standards and expanded access is not required until level 3.
Were the practices volunteers or were they targeted.	They were targeted and represent practice leaders who are affiliated with the largest IPA, large PCP group practices, and the most progressive health center.
What is your strategy to increase the amount of money paid into primary care?	We are holding health plans accountable to report publicly on costs. I am working with a separate Advisory Council to develop standards of affordability that plans can implement themselves. One standard is to increase the amount of dollars going to PCPs. It remains to be seen how it will play itself out.
Is there any additional money to cover the costs of installing EMRs?	No. This project assumes either you have one or can find the money to cover these costs.
How do you define EMR?	NCQA does not require an EMR. Practices can use paper tracking systems.
What are your observations about EMRs?	Practices without them have a harder time meeting NCQA standards.
What are the demographics of the population served by the health center?	The health center is in Woonsocket, which is a very economically stressed area. The health

Question and Comments	Speaker's Response
	center has strong leadership.
How did you decide on a 2-year pilot and what is next if the evaluation is not definitive?	I do not expect the evaluation to be definitive, rather it will be directional. Two years was selected because it was doable for the plans. My expectation is that we cannot go back after the pilot has ended.
Are there any examples nationally where a medical home has assumed full risk?	No. Once you adopt a multi-payer perspective, there is a need to go to the lowest common denominator or a more simple payment system.
Are there any patient incentives?	The self-insured company participants have a separate subcommittee to look at patient engagement. Little has been done.
Are you doing anything to build or retain PCP services or to address areas of dissatisfaction?	This is not a retention program. Our other initiative to increase PCP spending is retention. The learning collaborative is creating great excitement.

VII. Presentation regarding pay-for-performance – Suzanne Felt-Lisk, Ph.D., Mathematica

Dr. Felt-Lisk provided the following information about pay-for-performance programs.

Pay-for-performance is a broad concept that covers any type of incentive (returned withhold, bonus, enhanced payments). The amount at stake must be enough to make a difference, which is generally thought to be 5%. The costs needed to bring about the improvements must be considered when determining payment amounts. Performance may be measured against absolute levels, improvement, or ranks against peers.

There are currently 258 P4P programs, almost 50% are directed towards hospitals, with 139 sponsors. The programs are claims based, but many now include lab results and pharmacy data so clinical measures are possible. P4P programs are moving to add specialists. In the future, we expect more outcome measures to be used, which will require that there be risk adjustments built into the model.

Research on the first generation of P4P programs indicates that they are of limited benefit. The study of Massachusetts P4P programs shows that 89% of physician groups have P4P incentive programs. Over half the groups reported that the programs had a moderate to significant impact on the group because the payers generally pointed in the same direction, so that there was enough money at stake to have an impact.

It appears that Massachusetts has practice characteristics that support P4P programs:

- There are many large provider organizations.
- There are complementary synergies for public reporting and network tiering.

- There are data aggregation structures in place for groups. This results in more credible rates and avoids problems of different payers having different practice findings. There is also energy around EMRs and interoperability.

When asked, providers disclosed the following views regarding P4P:

- Providers are generally supportive, but often do not understand program specifics. This has become a bigger issue as the programs get more complex.
- Since providers have a case-to-case perspective, they are bothered with one case does not fit into the P4P model. They feel that they are being penalized when this variation occurs.
- Providers worry that P4P does not account for problems with patient adherence to treatment plans. This is a bigger problem for lower-income patients, and leads to the possible problem of non-compliant patients being kicked out of the practice. Possibly P4P programs should pay more when providers are working with difficult groups.
- Providers have trust issues with claims data.
- The measurements must be actionable.
- Providers are frustrated with different payers each having their own measures.

When implementing a P4P initiative, Dr. Felt-Lisk recommends considering the following:

- The implementation effectiveness;
- Obtaining physician input into the selection of the measures;
- What communication approach can get the physician's attention;
- The importance of providing feedback with the bonus: explaining what was left on the table and why;
- Providing an opportunity for the providers to correct the underlying data, which involves a commitment to a review and correction process, and
- Providing supportive knowledge-based efforts.

Dr. Felt-Lisk provided the following lessons learned:

- Match the terms of payment to desired outcomes;
- Use a broad and balanced set of measures;
- Anticipate physician reaction and work for a trusting relationship;
- Remember that the size of the incentive is important;
- The infrastructure that the physician practices have will influence the effectiveness of the incentives, and
- Physician engagement is critical.

Dr. Felt-Lisk offered the following closing thoughts:

- P4P on its own cannot be effective, but it may be used with other initiatives very effectively.
- It is important to remember the consumer/patient and monitor access to assure that there is no inappropriate exclusion of patients.
- Consider parallel rewards. For example, P4P could go very will with the PCMH because both have the same goals.
- It takes time and resources to develop and implement a P4P program. Whether a provider has the necessary resources impacts his or her ability to respond to the incentives. It may take some time to build the needed infrastructure.

VIII. Discussion of Pay-for-Performance

Commissioners' Questions and Comment

Questions and Comments	Speaker's Response
Physician concerns are the same whether you are paying or not paying them. These concerns relate to the public discussion of provider competence. This is a very difficult problem to address.	I agree.
An enormous variation in measures impacts the provider's ability to move the needle. Alignment of quality measures and a unified multi-payer focus may be a principle to add to our list of principles.	Good comment.
Is there any way to address issues of overuse and misuse of technology?	Some payers are adding efficiency measures. It is very data intensive to identify the problem.
What happens when a provider has patients with co-morbidities?	Most P4P programs are around primary care services and process measures, which are needed regardless of the population. NY pays for each category that the patient is in, and in that sense double counts the patient.
P4P is not sufficient alone to outweigh FFS incentives. Blue Cross has combined P4P with global payments that incentivize PCMH attributes.	No comment.
Is there any evidence that one vehicle works better than another?	There is anecdotal evidence that withholds are look upon as severe and not appreciated, but they do get the provider's attention. Size of payment is the biggest factor. There is some evidence that utilizing a group of interrelated incentives (public rating, tiering and P4P) creates a more forceful incentive.
Is there any research that unbundles the impact of the dollars paid and the publicizing of performance information?	Research on the impact of public reporting alone is not encouraging. Both together are best.
The payments help get resources to the providers to enable them to make necessary changes. They must go together.	No comment.

IX. Presentation regarding the intersection between payment model and benefit design – Deborah Chollet, Mathematica

Dr. Chollet discussed the intersection between payment models and benefit design, explaining that providers are frustrated when consumer and provider incentives are not aligned. Some payers are aligning incentives through benefit design. Dr. Chollet discussed two types of

benefit design strategies: consumer directed health plans (often called "high deductible plans plus spending accounts) and tiered networks.

These benefit design strategies are variants on evidence-based purchasing. Evidence based information is being developed by AHRQ, which is issuing 5-year contracts to hospital-based organizations to develop evidence based reports around clinical, social science/behavioral health and economics. All are focused on high cost, high volume Medicare/Medicaid services. Kaiser Permanente and Harvard Pilgrim have undertaken managed care initiatives. State initiatives are centering on drug effectiveness, and health care technology.

Consumer-directed Health Plans
Consumer-directed Health Plans (CDHP) use high deductibles coupled with personal health spending accounts to increase consumer accountability for health care spending. It may be coupled with consumer information about cost and quality. Implementation has been different from the model:

- Employers are not fully embracing them and employees do not trust them.
- There is a risk of under-use of services and obtaining follow-up services.
- Only half of the plans have personal health spending accounts and only half of those employers make a contribution.
- Some focus on consumer information, but most do not. It is not clear how successfully information is understood by the consumer.

There have been few plans to evaluation, so it is difficult to know what is happening. When offered as an option, the enrollees who enroll are higher income, and healthier. Most are men. There is also insufficient information regarding cost savings, since the rate of spending increases considerably after the deductible is met. Enrollee satisfaction appears to be lower, possibly because enrollees do not understand the risk they are assuming until they need services. It appears that benefit design impacts actions, but we do not know the best design. We do know that if someone has a health event, they return to a richer plan during open enrollment.

Questions and Comments	**Speaker's Response**
Are there any programs that limit enrollment in high deductible plans until the personal health spending account has sufficient funds to cover the deductible?	No
Is there any evidence about the severity of illness once the patients with these plans get to the hospital?	No. I think in states with these plans, there is more bad debt in hospitals. In Indiana we saw evidence of insufficient primary care and high hospital bad dept.
Rhode Island has passed legislation requiring payers to assume the responsibility for collecting co-pays and deductibles after the hospital has made a good faith effort to collect.	This approach would address the issue of bad debt, but not the issue of people getting care late.

Tiered Networks
Tiered networks encourage consumers to choose high quality, cost-effective providers. They assume that consumers make better decisions about health care when they have access to good cost and quality information. To date, tiered network plans hold low market share.

There are three conditions for effective tiering:
1. Tiering uses valid and accepted performance measures;
2. Consumers understand the incentives and quality measures, and have access to high-quality providers.
3. Providers receive the information necessary for them to improve performance.

The most recent development in tiered network plans is the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs in April 2008. It was developed by a consumer-purchaser and labor organization coalition. It commits insurers to:
- Periodic independent review of physician reporting programs
- Abide by standard criteria for physician performance measurement, reporting and tiering programs, and full public disclosure of performance results against minimum standards and national benchmarks.

The GIC and BCBSMA have tiered network products available. GIC tiers specialists and hospitals. BCBSMA tiers hospitals and PCPs. Tiered products are problematic for physicians who have only a few plan members and get put in the middle tier, which feels punitive. This is an argument for an all-payer approach. Consumers are concerned when they want to move to a lower tiered practice, but the practice is closed or does not take certain types of insurance, such as Medicaid. If payer and patient incentives are not aligned, neither is effective by themselves.

X. Discussion of Tiered Networks

Commissioner Questions and Comments:

Questions and Comments	Speaker's Response
To make tiered networks work there must be freedom of choice across plans and providers.	No comment.
There can be different tiering within practices, so the patient does not want to see the covering doctors. This can increase the problems of PCP shortages if not done right.	No comment.
The CDHP model does not work with publicly funded consumers.	No comment.
What is the right model for getting consumers involved? If they do not have skin in the game, it is hard to get them involved.	No comment.
We know that Massachusetts has high health care costs because of the high use of academic settings. Are there benefit designs that guide away form academic centers? Are there other services – lab or radiology – that could be	No comment.

Questions and Comments	Speaker's Response
tiered to guide consumers? How do we guide consumers to high value services?	
How can you guide consumers who do not have much choice to reach high performing providers?	No comment.
You can assure that everyone has access to high performing providers by improving the performance of poorer performers. Medigap also protects the consumer from cost impacts. Maybe we should consider mandatory co-pays. There is lots of overuse of imaging services. To do this we need standards of care which identify what we do not want to pay for, what is appropriate care. Currently, plans are not getting to the level of appropriate care, but are using a more broad brush. Congress is debating establishing a comparative effectiveness study organization.	No comment.

The meeting ended at 2pm.